STATE OF ARKANSAS

ARKANSAS STATE EMPLOYEES SALARY REDUCTION AGREEMENT ("SRA")

This Salary Reduction Agreement authorizes your employer to reduce your salary by the indicated amount shown below for the purpose of facilitating a contribution to your Health Savings Account ("HSA").

Do not complete this form unless your have elected the HSA PPO option offered by NovaSys Health.

EALTH SAVINGS ACCOUNT ELIGIBILITY INFORMATION: In order to establish an HSA, you must be classified as an "Eligible Individual" under IRC Section 223, s sub-sections and applicable rulings and provisions, collectively called the "Code". You are eligible for an HSA ***ONLY*** if you can meet the following equirements: (1) you are covered by a high deductible health plan ("HDHP") (the HSA PPO offered by NovaSys Health is a qualified HDHP); (2) you are not overed by another health plan that is not a HDHP; (3) you are not able to be claimed as a dependent by another taxpayer (excluding spousal dependents); 4) you are not entitled to benefits under Medicare.

y completing this agreement, you are indicating that as of the effective date of your contribution election, you are an "Eligible Individual" s defined above and authorize your employer to facilitate your monthly contributions to your Health Savings Account on your behalf.

Instructions

Step 1 Complete the **PERSONAL INFORMATION** section. All information is required.
Step 2 Complete the **HSA CONTRIBUTION ELECTION** section with your total monthly contribution amount.
Step 3 Sign in the **SIGNATURES** section and return to your Agency Insurance Representative (AIR) or other designated HR person.
Please Note: Upon enrollment in the HSA PPO & submission of this agreement, you will be mailed an HSA Welcome Kit including the account application, account disclosure, interest rate, and fee schedule.
For more information on the HSA, go to www.ArkansasHSA.com or call 1-877-685-0655.

PERSONAL INFORMATION

NAME: (please print) _____
(First) **(M.I.)** **(Last)**

MAILING ADDRESS: _____

PHONE: _____ **E-MAIL:** _____

DATE OF BIRTH: _____ **SOCIAL SECURITY NUMBER:** _____

DEPARTMENT / AGENCY NAME: _____

HSA CONTRIBUTION ELECTION

I ELECT A MONTHLY CONTRIBUTION OF $ _____ **TO MY HSA EFFECTIVE** _____.
Amount Date

The monthly contribution amount may not exceed 1/12 of the annual deductible of the HSA PPO plan.
Single deductible of $1,250 ($104.16 monthly contribution limit) / Family deductible of $2,500 ($208.33 monthly contribution limit).
Catch-Up contributions are allowed for Eligible Individuals who are 55 years of age or older but younger than 65 years of age.
Attention current MSA or HSA account holder with accounts at other financial institutions, please remember that the total annual contributions to all accounts may not exceed federally mandated limits.

SIGNATURES

Employee Signature: As of the effective date of my HSA Contribution Election, I certify that I am an "Eligible Individual" as defined by the Code and do hereby elect a Health Savings Account in accordance with Section 223 and Section 125 of the Internal Revenue Code. I understand this request will not be processed until all paperwork is completed, accepted and approved by my employer. I also realize that the election I have just requested is an irrevocable election for the length of the plan year unless I experience a qualifying change in status as defined by my plan or the Code. I further understand that I am responsible for all contributions made to my HSA and that DataPath Administrative Services, Inc. is facilitating but not initiating the contribution.

Employee Signature: _____ Date: _____

Employer Signature: The employee's election of the Health Savings Account Contribution is accepted as of the date shown below.

Authorized Signature: _____ Date: _____

Attention Agency Insurance Representative or Human Resources Department:

Please return this form to: DataPath Administrative Services, 1601 Westpark Drive, Suite 9, Little Rock, AR 72204